



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHMED KHALIFA MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name

TEXAS COUNCIL RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 43

MFDR Tracking Number

M4-11-2415-01

MFDR Date Received

MARCH 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay total amount due for services rendered even after a request for reconsideration was submitted."

Amount in Dispute: \$244.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 4, 2010	CPT Code 99204	\$0.68	\$0.00
	CPT Code 95861 (X1)	\$0.54	\$0.00
	CPT Code 95900(X4)	\$0.96	\$0.03
	CPT Code 95904 (X4)	\$217.02	\$216.15
	HCPCS Code A4566	\$25.00	\$0.00
TOTAL		\$244.20	\$216.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, 33 *Texas Register* 364, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 45-Charges exceed your contracted/legislated fee arrangement.
- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W1-Workers compensation state fee schedule adjustment.
- 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 18-Duplicate claim/service.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- 247-A payment or denial has already been recommended for this service.
- W3-Additional payment made on appeal/reconsideration.

Issues

1. Does the documentation support a contractual agreement issue exist?
2. Is the requestor entitled to additional reimbursement for CPT codes 99204, 95861, 95900 and 95904?
3. Is the requestor entitled to reimbursement for HCPCS code A4566?

Findings

1. The insurance carrier reduced or denied disputed services with reason code "45-Charges exceed your contracted/legislated fee arrangement." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The issue in dispute is whether the requestor is due additional reimbursement for the disputed services.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2010 DWC conversion factor for this service is 54.32.

The Medicare Conversion Factor is 36.8729

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77027, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

Using the above formula, the Division finds the following:

Code	Calculation for Locality Houston	Maximum Allowable	Carrier Paid	Due
99204	(54.32/36.8729) x \$158.47 for 1 Unit	\$233.45	\$233.46	\$0.00
95861	(54.32/36.8729) x \$123.95 for 1 Unit	\$182.59	\$182.59	\$0.00
95900	(54.32/36.8729) x \$55.58 for 4 Units	\$327.51	\$327.48	\$0.03
95904	(54.32/36.8729) x \$48.91 for 4 Units	\$288.21	\$72.06	\$216.15

3. The requestor is seeking dispute resolution for HCPCS code A4556. According to Medicare policy this code is a bundled code; therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due for the specified services. As a result, the amount ordered is \$216.18.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$216.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	10/10/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.